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ABSTRACT

This paper is based on the premise that culture creates realities that include a repertoire of symbol interpretations and communication patterns on which people automatically draw, and that this pattern is as manifest in professional cultures as it is in national or ethnic cultures. The paper takes a systematic look at hospital nursing culture, how it influences the role perceptions and communication patterns of those who are part of it, and what impact this may have on the present nursing crisis. Data for the paper came primarily from interviews with 63 nurses (aged 24-55) from 17 different hospitals in a large metropolitan area. The paper finds that among those nurses already in the profession, the disaffection and burnout rate is high. The paper hypothesizes that the roots of discontent lie within the nursing culture itself and points out that even in nursing school, education is focused at a "skills" level and that the analytical frameworks that are given to physicians are absent from most nursing curricula. The paper concludes that long-term, workable solutions can only be found if the nursing profession develops a deeper understanding of its own patterns and assumptions. A figure containing the interview questions is included, and 22 references are attached. (Author/NKA)

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A CULTURAL ANALYSIS OF STRATEGIES OF POWER IN HOSPITAL-BASED HEALTH CARE

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ABSTRACT

Culture creates realities that include a repertoire of symbol interpretations and communication patterns on which we automatically draw. This pattern is as manifest in professional cultures as it is in national or ethnic cultures. Shared values, language and role assumptions allow for predictability where there would otherwise be chaos. The higher the inherent potential for unpredictability, the more powerful the cultural roles become. Medicine in general and nursing in particular fall into this category. Introducing change into such an entrenched cultural system can be devastating. In times of crisis, clinging more tightly to traditional roles and cultural patterns is a natural response. Even those who shout the loudest for change, do so with the grammar of the old order. At present there are more women entering medical school than nursing school. Among those already in the profession, the disaffection and burnout rate is high. For a decade, hospitals and nursing professionals have sought answers to these problems. However, most solutions have been stop-gap measures at best. This paper presents the hypothesis that the roots of discontent lie within the nursing culture itself. Long term, workable solutions can only be found if the profession develops a deeper understanding of its own patterns and assumptions. This paper will explore the processes, assumptions, rules, roles, and communication patterns that lie at the base of nursing culture. It will address how these components serve to undermine the demands and concerns of nurses today.

Introduction

Nursing is in a self-proclaimed crisis. By the end of the century, it is forecasted that the demand for nurses will be double the supply. Already 14% of large urban hospitals and 9% of small urban hospitals are turning patients away because of this shortage. The reasons are twofold. Large numbers of skilled nurses are suffering what has been labeled "burnout," a term used to describe a wide variety of complaints that result in feelings of extreme stress, anxiety, frustration, disaffection, and a growing exodus of nurses from the hospital and frequently out of nursing altogether. In addition, nursing schools are finding it increasingly difficult to recruit students. At present, the number of women entering medical school surpasses those entering nursing schools (Will, 1988).

Even though the last 20 years has seen an increasing number of male R.N.'s, nursing has historically been and still remains primarily a woman's profession (only 3% are men) (Will, 1988). They have been called "angels of mercy" and the "doctors' handmaidens." The connotations of these descriptive phrases speak volumes about the roles, rules, values, and communication behaviors, i.e., the *culture*, that surround the profession and the people within it. The *angel of mercy* is a cool hand on a fevered brow, a comforting hand in time of pain, pure and ever selfless in her devotion to the care and comfort of others. The *doctor's hand-maiden* is obedient, always there, always ready to do what her master, the physician tells her. Nursing has, in other words, institutionalized the traditional female roles of nurturer, help-mate, selfless companion, and caretaker. It really matters very little if the nurse or doctor is male or female, the *roles* have been defined along gender lines for over a hundred years. At a time when women and men have begun to question the

efficacy of these old roles in a modern world and redefine what is open to and possible for people of both genders, medicine in general and nursing in particular remain the last bastions of a rigid and out-dated patriarchal system.

This paper will take a systematic look at hospital nursing culture, how it influences the role perceptions and communication patterns of those who are part of it, and what impact this may have on the present nursing crisis. Data for this paper comes primarily from interviews of sixty-three nurses from seventeen different hospitals in a large metropolitan area whose ages ranged from 24 to 55. Fifty-eight were women, and five were men. Of these interviews, 25 were individual and 38 were done in focus groups ranging in size from three to five. The type and amount of response did not vary significantly in any of the contexts described. Interviews were conducted for the purpose of developing curriculum for nursing communication and nursing burnout.courses at a private university. The interview questions are provided in **Figure 1.**

Lakoff states that, "we can use our linguistic behavior as a diagnostic of our hidden feelings about the world. ...we can interpret overt actions, or our perceptions, in accordance with our desires, distorting them as we see fit. But the linguistic data are there in black and white, or on tape, unambiguous and unavoidable" (pp. 3-4). In the spirit of this statement, the words of the nurses interviewed will be used to illustrate the premise that the cultural patterns which have defined nursing roles and communication behaviors within the hospital environment for so long have become destructive. Their voices speak powerfully of the frustrations and concerns that they share.

Figure 1

Interview Questions

How would you define yourself as a "nurse?"

What do you think is the most important thing about being nurse? How do "you make a difference?"

What do you find *rewarding* about nursing in general?

What do you find *frustrating* about nursing in general?

What do you find most *challenging* about what you do as a nurse?

How would you describe your relationship with the doctors that you work with.

Are there specific difficulties that you have dealing with doctors?

How would you describe your relationship with other nurses that you work with?

Are there specific difficulties that you have dealing with other nurses?

How would you describe your relationship with the hospital?

How would you describe your relationship with the patients that you care for?

Are there specific difficulties that you have dealing with patients?

What would you like to change about the nursing profession?

What elements of nursing would you want to keep the same?

How do you see burnout affecting nurses in general?

Do you ever feel "burned out?"

What do you think is the most important thing that you as a nurse contribute to patient care?

All discussion of "nurses," "doctors," and "hospitals" are of course generalizations. Individual variation, occasionally wide variation may exist, but the trends discussed here were patterns that emerged again and again in the interviews conducted.

Boundaries

A group's boundaries may be physical and/or psychological, but deciding on specific definitions for those boundaries is crucial for both the group being studied and the investigator. To some degree, the definition of boundaries will always be arbitrary, based on assumptions and decisions about what is important to the investigator. For the purpose of this study, "Nurses" are defined as Registered Nurses (R.N.'s) working within the confines of the hospital. Beyond a desire for a reasonably parsimonious focus, there are two reasons for these parameters: (1) Within the nursing profession, it is the R.N. not the LPN who is considered "professional," and increasingly, the stress is on attaching that label only to R.N.'s who have gone through a four year (rather than two or three year) program. (2) While there are obviously other contexts in which nurses practice (nursing homes, home and community health care, and industrial settings are the most common), and while the boundaries between these contexts remain permeable, it is hospitals which employ the greatest number of practicing nurses and the hospital which provides the primary training ground for all nursing students. It is in the hospital that the culture becomes ingrained. Nursing is a profession whose cultural paradigm is rooted in the hospital and radiates from the patient's bedside.

Defining Perspectives

It is important to realize that nurses, like all people, operate within a larger context. Assumptions that are made about roles, identity, values, and communication behaviors are interdependent with those of the larger system. In the same way that nursing has institutionalized the "female" role as it is defined in an industrialized society, physicians have institutionalized the "male" role. They are two halves of a greater whole who have traditionally

defined themselves as complementary opposites. As medical care has become increasingly costly, the medical institution (primarily the hospital) has taken on the role of the factory/corporation utilizing its workers for the sole purpose of making a profit. All have different purposes and goals, but within the hospital system, those of the nurse/women have been systematically devalued, while that of the physician/male has been systematically elevated. For while it is the nurses who are the primary work force, it is the physicians who are seen as the *income generators* (Bernard, 1981; Gould, 1983).

Barnlund (1982) defined *communication* as "the process of creating a meaning" (p.78). The Zen-like simplicity of this statement has profound implications for the study of human interaction. The word *process* implies that our communication behavior is not static and is responsive to and interdependent with the communication behavior of others. *Creation of meaning* assumes that meanings [and therefore social realities] are subjective commodities which are negotiated/created through communication and are intrinsically tied to our perceptions of the people, contexts and events around us. Given these assumptions, it is not sufficient to say that nurses are unhappy simply because physicians are unwilling to give them the "respect they so richly deserve," or because the hospital is unwilling to pay them "what they are worth." It is assumed that their own communication behaviors contribute to the creation of the meanings and situations they find so untenable.

The Medical System: Opposing World Views

Under the umbrella of a western, biomedical perspective on health care, the nurse, the physician and the institution have all developed separate and

unique perspectives on the running of the hospital and the care of the patient. From the nurse's perspective, the patient as *individual* is central to the system. From the physician's perspective, the patient as *disease* and the *practice of medicine* (sometime synonymous with the physician in a generic or metaphorical sense) share center stage. From the hospital/institution's perspective, the patient as *income* is the main focus. While the doctors' and the hospital's view of care is often relatively compatible (the practice of *good* medicine in the western world requires an increasing amount of money), the nursing perspective finds itself increasingly at odds with the other two. Comments about the "the system" from the nurse interviewed tended to share common themes of feeling alienated, frustration, and adversarial:

> "The hospital's priorities are unbelievably stupid. They spent a fortune to put new wallpaper and carpeting in the doctor's lounge -- it looks like a whorehouse in there, but can't find the money to buy us a new monitoring system for the [intensive care] unit!'
>
> "Ordering patient supplies has become a nightmare. Everything comes in "kits" that cost the patient a fortune. Using a dressing package costs three times as much as a few 4 x 4's [bandages] and a betadine swab [antiseptic] and it's essentially the same thing. We're always trying to find a way to get around it."
>
> "The hospital was worried about the nurses being more 'professional.' Their solution was to have us wear our caps more. They're always in the way -- they get caught in the bedside curtains, and studies have shown they're the dirtiest part of our uniform because they're impossible to wash. I mean, to the administration, a nurse is as good as her hat. Some definition of 'professional!'"
>
> "The director of nursing service is an idiot! If you're incompetent at the bedside and good at talking nonsense, you get promoted to a job like that."
>
> "They built a new orthopedic unit at the hospital. Spent millions on it and never asked the nurses for input on the design. It looked great, but it was a nightmare to work in. You couldn't even get a wheelchair through the bathroom doors!"

It is worth noting here that the increasing involvement of insurance companies in deciding the financial imperatives of patient

care has very likely helped to upset the balance of power and intensified the adversarial nature of the physician/hospital/nurse triad. The defining issues of profit (hospital), diagnosis and treatment (physician) and care (nurse) have all been compromised to some degree by the financial imperative of what insurance companies will and won't pay for.

Values

At the base of any cultural system are the values that the system embraces. Albert (1968) defined a value system as representing "...what is expected or hoped for, required or forbidden. It is not a report of actual conduct, but is the system of criteria by which conduct is judged and sanctions applied" (p. 347). Values are the elements of a culture which define one's relationship to the people and institutions around them and provide the basis for judgements about what is "good or bad," "right or wrong." In short, they provide the basis for what we believe, how we behave and communicate, how we define *morality*, and how we judge other people's actions. While the male pattern of determining "right" and "wrong" finds its basis in the notions of "impartiality" and "blind justice," women have traditionally centered their moral development around notions of *care and responsibility* (Gilligan,1982). From this perspective, moral and personal choices can be made intuitively and inductively rather than deductively, looking to the context and the individuals involved as central in the process of decision-making. This same value of physically and psychologically "caring for others" and placing others (patients) at the center of the decision-making process is posited to be at

the core of all nursing practice (Leininger, 1985). The nurses interviewed expressed this value repeatedly.

> "If it wasn't for the patients, I wouldn't be here. (Laughs) I guess that sounds obvious doesn't it. What I mean is, I feel as if I really make a difference in their lives and that makes up for a lot of the other frustrations that go along with the job."
>
> "When you get down to it, I do it for the patients. There are people I know would have died if I hadn't been there. It's hard to explain how that feels, but it's incredible!"
>
> "Sometimes a patient or family will say thank you in a way that lets you know they really mean it, you've done something for that particular person that touched them somehow. That makes it all worth it.""
>
> "One of the things that makes us different from doctors is that we're there for people *all* the time. Doctors see themselves as healers, you know? If someone dies, it's a sign of failure. They don't deal with it very well. But we need to be there to help people die as well as help them get well."

Identity

It has been suggested that the responsibility orientation is more central to those whose identity is rooted in a sense of connectedness and relationship to others (Gilligan 1984; Lyons,1983). While this is certainly not a female-specific trait, it is a focus which has been most frequently identified with regard to traditional female roles (Chodorow, 1978; Gilligan, 1982; Miller, 1976). Miller (1976) specifically suggests that women develop a psychic structure whose organizing principle is "the attempt to transform their drives into the service of another's drives; and the mediation [of those drives] is through the other person's purposes in that reality " (p.72). Among the nurse I interviewed, the issues of identity, service, responsibility, and relationship are frequently discussed together.

> "I went to nursing school because it seemed like a good way to make a living. But I found a great deal of satisfaction in the idea that I was

really *helping* people. I feel sort of connected to my patients, responsible to them for seeing that their taken care of properly."

"In spite of all the frustrations of the job, the bottom line is often that *I do make a difference*-- patients feel better, get better because of the things I do. That makes me proud to be a nurse."

I realize sometimes how much being a nurse is part of my identity. Friends introduce me as '_____, she's a nurse.' That always gets a response out of people, they suddenly are interested, feel as if they know who I am or something. "

"The other day, my sister said of a nurse friend of mine, 'With that face she would have to be either a nun or a nurse!' Can you imagine! We really are seen by people as 'angels of mercy.' What's weird is, I realized that we tend to think of ourselves that way too. We're there to take care of our patients. That often means running interference with the patient's family, friends, the hospital, and mainly doctors! We take on this incredible sense of responsibility about it all."

In the same way these nurses draw identity sustenance from the patients they care for, they experience a starvation of self from the lack of positive reinforcement from peers, physicians, and the institutions that employ them. It has been suggested that one's image of self emerges from the roles (s)he performs. Who we are and what we believe are implicitly tied to what we do (Bem, 1970 ; Moreno, 1962). As a result, our self-concepts are tied to the roles we take in life and how well we perform them. Often the only resources we have for relating to others are the roles we enact with them. When we begin to devalue our roles, we may also begin to devalue ourselves (Barbour & Moreno, 1981). This is particularly true for those who have little role distance (Goffman, 1959) as is indicated in the preceding comments. To be a nurse, provides for many a definition of self which springs from a deeply held value orientation which is powerfully reinforced by the culture at large. However unsatisfying the role may seem, separating one's self from it is extremely difficult. The nurses interviewed expressed frequent frustration, depression, and anger about how they felt

under-valued, unappreciated, and stuck in a job that eventually became stifling. The concerns expressed over and over had to do with issues relating to self-esteem, and self-realization (Maslow, 1968). Even when money/wages are mentioned it is within the implication that high pay in this culture connotes respect and success.

> "It's all so frustrating. I mean no one really appreciates what we do except sometimes the patients. You take crap from everybody--the doctors, other nurses, patient's families. I hear all this talk about 'professionalism,' but the fact is, we're not professionals, we're underpaid laborers. The grocery clerks at _____ make more money that we do."

> "I think I'd be happy with the money I make if I felt it was all worth it. I mean, we work crummy hours, do most of the things doctors don't want to do, and nobody gives you any praise."

> "It's a dead end job, that's what I hate the most. I worked hard to get where I am [Intensive Care]. But there's no place to go from here either job-wise or money-wise if you don't want to get into management, and I don't. I didn't become a nurse to shove papers around and deal with administrators. I wanted to take care of people and I'm darn good at it! I guess that's part of the frustration. I'm either stuck here or I stop doing something I've spent years learning to do well. I don't know how to *be* anything else. *I'm a nurse.*"

> "There's a lot of burnout around here these days: nurses just packing it in and going home to raise their kids or start a little business, or whatever. I have a couple of friends who quit and opened a coffee shop. Sometimes it worries me. I still like what I'm doing most of the time, but things get to me, and I wonder: In three or four years, will it still be worth it?

Power

Power is a concept that is central in understanding the workings of interpersonal relationships (Wilmot, 1987). As Deutsch (1973) states:

> It is a relational concept; it does not reside in the individual, but rather in the relationship of the person to his [her] environment (p. 15).

Therefore, in any situation, having "power" is contingent on one's ability to *define the situation* one is in. However, power is not necessarily synonymous with *dominance* (Wilmot, p.134).

Feeling *powerless* was an issue that was constantly on or just under the surface of much of what was being said. There is an undercurrent in all the interactions nurses describe with doctors and even other nurses. Miller (1976) suggests that "The words 'power' and 'self-determination' have acquired certain connotations [that]...imply certain modes of behavior more typical of men than women" (p.115). Certainly, the nurse/female most frequently sees the physician/male as not only having all the power, but as being unwilling to "give it away." Power was not conceived of as something that they would be able to *take*, and certainly not something *internal* that they already had and could share with others.

An article in *RN* (1988) magazine revealed the contents of a survey of nurses' opinions of physicians. The anger was apparent; "doctors" were labeled as "lazy," "inconsiderate," "male chauvinist pigs," "SOB's," "arrogant," "insensitive to patients," "rude," and "sexist." However, the underlying message is one of powerlessness in the face of all these apparent flaws.

> "Doctors treat nurses like dirt."
>
> "I work with a doctor who flies off the handle at the slightest mistake."
>
> "I can be talking to a patient, and the doctors will butt in and just start talking. It's as if I wasn't even there."

Similar descriptions, and ethically more disturbing ones were common among the nurses I interviewed.

> "One of the OR [operating room] nurses in our hospital was seriously injured by a surgeon because she passed him the wrong scalpel. He handed it back to her in a rage, blade first and cut her hand badly--the tendons were damaged. When she threatened to sue, the hospital told her to drop it or she'd never work in the city again. What's scary is that she did drop it."
>
> We had a young Hispanic girl, 16, I think, who had facial injuries from a car wreck. She was drunk and delirious and the resident on call was teaching a first year intern how to suture on her face. I remember he

> said,' If she was from ...[a better part of town], we'd call in a plastic surgeon, but this won't make any difference to *her*.' They hadn't even talked to the girl's family about it! What was awful was that I continued to assist him even though I knew it was wrong. I tried to suggest we wait, but he ignored me, and I just let it drop.
>
> "One of the surgeons started yelling at me about something he didn't like about the way I was caring for a patient of his right at the patient's bedside! It was humiliating, and probably scared the patient to death. There was nothing I could do but stand there and take it."
>
> "We all know doctors who are out of control. They rage, they throw things, they blame all their mistakes on the nurses. You talk about them, complain about them, sometimes other doctors even sympathize, but nobody ever *does* anything about it."

These examples detail more than just a power differential, they are stories of serious *abuse*. The parallels to spouse abuse are striking. In their discussion of "silent women" and abusive relationships, Belenky, *et al* (1986) state that

> The extreme sex role stereotypes that silent women accept reflect the powerlessness that they have experienced. ...The actions of these women are in the form of submission to the immediate commands of authorities, not to the directives of their own inner voices. ...[they] see blind obedience to authority as being of utmost importance for keeping out of trouble and insuring their own survival (pp. 28-29).

These nurses have come to realize that the way they are being treated is wrong, but they see no way out of the cycle of abuse. Survival within the system seems to demand that they "take it." The psychology of victimization is very pronounced. What is bad is being done *to* them, and they feel powerless to stop it. There is no question that the behavior of the physicians that these nurses describe is inappropriate and unprofessional, but the first step toward stopping it is to refuse to accept it. As Aboulafia (1986) states:

> Those who claim they are endowed with the right to be at the top dupe themselves; the master is not the independent power he believes himself to be, for his self-consciousness is *dependent* upon the slave's consciousness.

> ...Without the slave he could not be the master; the slave's consciousness *recognizes* him as the master (p. 183).

Even within their own sphere of domination, many nurses felt extremely uncomfortable with differentials in power.

> " I have no trouble taking care of my patients, helping other staff, seeing that things get done properly, but I just hate disciplining people."

> "I have a charge nurse who is a little Hitler half the time. There's one right way to do everything and that's her way. I used to just let her bully me, then one night she pulled her act on a male nurse who had floated into the unit and he turned to her and said, 'Back off, _____, I know what I'm doing!' I couldn't believe he stood up to her like that, but it worked. I learned something about standing up for myself."

Communicating with Each Other: An Absence of Collegiality

Iahara (1988) defines collegiality as having a professional *attitude* which manifests itself in *mutually supportive behaviors* . This attitude spring from "mutual respect" and "commitment" to professional values and skills and from a sense of "connectedness," of being part of a "larger, interdependent whole." While collegiality is clearly present among physicians, it is remarkably absent in the nursing profession. If fact, the nurses I interviewed seemed openly hostile to degree of solidarity physicians displayed often referring to it as a "good-old-boy" network which contributes to malpractice and unethical conduct on the part of doctors. "Even the good one's will look the other way when they know that a particular doctor is incompetent--even when it has resulted in the death of one or more patients." However, they also complain about the difficulty they have dealing with other nurses because they exhibit just the opposite behavior.

> "You always feel as if someone is looking over your shoulder, waiting for you to make a mistake. Sometimes its the doctors, but more often it is the other nurses you work with."

> "One shift is critical of another shift, patients (and their records) who have been transferred into the unit from another floor are gone over

with a fine-toothed comb. It's obsessive. It's as if we *want* to find mistakes. I've done it, everybody's done it at some time. The *Incident Report* is the core of our existence."

"A nurse can be really good, never make a mistake, and no one says anything. It's just expected -- the idea that your perfect. But then you make a mistake: your tired, or the unit is really busy, or your having a personal crisis, or maybe it's just time because nobody's perfect, and your whole career can go down the drain. I've seen it happen."

The pattern for communicating with other nurses with suspicion and hostility begins in nursing school. Many nurses discussed the difficulties of getting through their nursing programs.

"I remember I was put in the hospital for a suspected bowel obstruction. It turned out to be just a stress reaction. My whole system had just shut down. I felt terrible. It seemed so neurotic! Then my doctor asked me, 'What's going on in that program of yours? We've got half the nursing students on valium, and the other half have been just plain sick.'"

"We all hated the end of term reviews. They had to find something wrong with what you were doing, even if it was petty. One friend of mine whose clinical skills were really good was criticized for how she wore her hair, another for standing with her hands in her pockets."

"Even in school I always felt as if I wasn't doing a good enough job. A mistake was so critical, even if it wasn't. I got in trouble once for calling a patient's catheter his 'plumbing' -- he understood me perfectly, but my instructor was livid. She said it was 'unprofessional!'"

"Ever since nursing school, evaluations have been the same. People tell you what you did wrong; never what you do right. It's as if they don't even notice."

This directly echoes the traditional patterns of expectations women have labored under for generations. Because a woman's work was "natural" work rather than "professional" work, she was expected to perform her tasks without difficulty. If she was a bad housekeeper, a bad mother, a bad cook, everyone felt free to comment and criticize; but if she performed these tasks well, praise was seldom given. The tendency of the female identity to be more closely tied to her relationships with others, and hence to the feedback of others created a double-bind. No matter how competent she was, it was

her flaws that were most frequently noticed. As a result, the need for self esteem could only be met by debasing the performance of other women. Mothers criticized daughters, and mothers-in-law criticized their son's wives, young women criticized other young women seen as their rivals for the admiration and approval of young men.

Communicating with Physicians:

Lakoff (1975) suggests that women, especially when talking with men, are much more likely than men to include tag questions ("This is what you wanted wasn't it?) or phrasing a suggestion as a question ("Shall we go now?"). These of course, are not genetic distinctions but cultural ones related to issues of power and politeness. This pattern was clearly present in the nurses' descriptions of how one "gets a doctor to to do what you want."

> "Their [doctors'] egos are so touchy! With most of them you can't just come out a make a suggestion for something a patient needs, you have to phrase it like a question, but make it so positive they can't refuse. It's like talking to my two-year old. Like you say, 'Did you want me to order the blood gases now or wait until tomorrow morning?' even though blood gases may be the farthest thing from his mind"

> "You want something from a doctor, you make him think it was his idea. I've had a lot of practice with that on my husband."

> "Doctors don't listen to your recommendations no matter how much experience you have. Most aggravating are the ones who ask for your advice and then do just the opposite!"

Patterns of Thinking

As previously stated, Gilligan (1982) believes that women tend make moral and personal choices intuitively and inductively rather than deductively, looking to the context and the individuals involved as central in the process of decision-making. Belenky *et al* (1986), describe this process in women as *subjectivism*. Women who have become competent, personally or

technically tend to shift from an external to an internal "expert" in their decision making. They state that

> ...women can have a difficult time identifying the new source of knowing and articulating the process. One women communicated a sense of inner conviction in the words "I just know."...Truth for subjective knowers is an intuitive reaction--something experienced, not thought out (pp. 68-69).

This inability to metalevel (think objectively about the processes at work) situations, behaviors, and reactions was a common characteristic of many of the nurses interviewed. Judgements about patient care decisions, diagnoses, and problem-solving were made intuitively, often correctly, but frequently with an inability to clearly specify why they were made.

> "Sometimes it's difficult to get a doctor to listen to your recommendations. You get a feeling about a patient, like they're about to go sour and you can't identify anything acutely wrong, but you just *know*. And I'm probably right 90% of the time."

> "It's hard to say how you know what you know about a patient sometimes. Maybe it's a tone of voice, or a look, or a particular kind of restlessness, but you know something is about to happen. Some doctors have learned to pay attention when a nurse has those feelings.--others never do."

The majority of nursing education and hospital experience is focused at a *skills* level. The analytical frameworks that are given to physicians are conspicuously absent from most nursing curriculum. They are operating from a different perspective, have a different way of knowing about their patients, and as a result, sometimes speak with a different vocabulary than the physicians with whom they must collaborate on a daily basis.

The difficulties that "a nurse's way of knowing" present are not limited to dealing with physicians, however. While they may feel extremely comfortable at the bedside [*caring* for patients was the reason they went into nursing], they were extremely frustrated with management requirements of discipline, maintaining control, and dealing with the ever increasing paper

work demands. They *knew* what to do for the patient, but felt ill equipped to define, describe, or supervise others in developing what, beyond simple mechanics, their intuitive knowledge told them to do. This inability to analyze and articulate their skills went hand in hand with their discomfort in wielding the power they had been given.

> "The problem with being in charge is that you're no longer concerned with taking care of the patient, but with how *others* are taking care of the patient. If they're good, it's no problem, but if they're not, your only choice is to watch and double check everything they do. It's exhausting. I mean, how do you teach a person *good judgement?*"

It is likely that the same reasoning processes that make it difficult for nurses to analyze patient diagnoses and care-taking behaviors, also complicate the process of solving the dilemmas and concerns that face the profession as a whole. Belenky et al (1986) make the distinction between knowing through a sense of separateness [objectivity] and connectedness [intuition]. The former is a traditionally male way [physicians], the second a traditionally female way [nurses]. Both ways view the world from perspectives that by their very nature block out the other view. They are separate, in opposition, yet dialectically necessary if one is to consider the whole. The need for this dialectic is perhaps one of the reasons that the medical system has perpetuated the nurse/physician dichotomy for so long. Yet it is a system that is crippling for both. If loss of perspective has limited nurses' ability to care for themselves, loss of feeling has also limited the doctors' ability to care for all of the human beings that populate their world. Integration of separateness and connectedness as ways of knowing results in what Belenky *et al* have described as *constructed knowledge*. Constructed knowledge assumes both the relativity of truth *and* the possibility that processes and frameworks for decision-making can be

identified and utilized within a given context. It requires both connectedness and objectivity. It is empowering on both a personal and a relational level. The assumption of such a knowledge base would profoundly change the physician/nurse dialectic, but the resulting synergistic relationship would likely be to the benefit of both.

Conclusion:

This paper suggests that the nursing crisis is not just a matter of long hours and short pay. It is the result of basic "cultural" and institutional assumptions which have led to communication patterns that are self-perpetuating and inherently destructive in today's environment. In the past, these assumptions and behaviors defined a system that provided workable solutions to the exigencies of the health care system. But they have failed to shift with the times. Our society has begun to realize that traditional gender roles create parameters that are unwisely restrictive to both sexes in meeting the demands of a modern world. We are recognizing both the inherent weaknesses and the inherent strengths that these roles may hold. If nursing as a profession is to survive the present crisis, it must recognize the patterns it has been weaving and make changes where they are needed. The old assumptions and rewards are no longer viable. Nurses are better educated. They are surrounded by a greater cultural system which no longer accepts the restrictive roles that they are expected to fill within the confines of the hospital. Nurses have moved beyond responding to bonus trips to Hawaii as an incentive to work for a hospital. Their need for self-esteem and self-actualization can no longer be found in selfless service. As a profession they have reached a turning point. They are acutely aware of their own discomfort

with that expectation, even though all of their socialization in the medical system has led them in that direction.

Tofler (1990) observes that the technology revolution has created a need for rapid, hands on decision-making that is short-circuiting the traditional hierarchies of decision-making power. As a result, he suggests that the power source for the 1990's and beyond will be *information*. The ability to utilize information and control its dissemination is at the base of this definition. Hospital nurses have long had this vital power source at their disposal. It is time they learned to recognize, value, and utilize the power they already possess. In the midst of a group interview, one nurse suddenly turned to her companions who were complaining about feeling powerless and said:

> "But we *do* have power, we just don't recognize it! We're the ones who are with the patients twenty-four hours a day. *We* take care of them, *we* know them, what they need, what's going wrong. Most of what doctors know about their patients they know because of us. We *are* the hospital!!"

The force of this statement shocked everyone at first. The implications were enormous. But the question of how to wield that power, how to make the doctors and the hospital see it and respect it remained. Miller (1976) suggests that "one of the major issues before us as a human community is the question of how to create a way of life that includes serving others without being subservient. Women today have a highly developed basis for this social advance. To achieve it, however, requires a new integration of the assets women already possess." (p. 71). This requires that women bring forth their qualities of authenticity (a strong sense of self) and creativity and learn to recognize and utilize the power they possess as individuals and as a group. "For women today, power may be defined as 'the capacity to implement'"

abilities that they already have (p.116). If we replace "women" in these statements with "nurses" the advice remains equally valid. The need for affiliation, relationship and caring must be extended to others in the profession to create the sense of solidarity and collegiality that Iahara (1988) talks about. It does not require that nurses remove their focus from its traditional centering on the patient, but *expand* it to include their own. It requires the integration of objective, analytical skills with their existing capacity for intuitive decision-making. In addition, the direction of modern medicine has made the traditional decision-making hierarchies inefficient and dangerous. Those who wish to survive the information revolution must develop communication channels that share and utilize the knowledge competencies of *all* people involved in a task (Tofler, 1990). To accomplish this, nurses and physicians need to realign their relationships and learn to *share* the decision-making responsibility of patient care and treatment.

Transition is never easy. Ending familiar patterns, however painful and dysfunctional they may have become creates grief and uncertainty. We cling to the old ways not just because they are the only ways we know, but because they have come to define us as individuals, and as actors in the larger system (Bridges, 1986). Change requires not only that we redefine ourselves, but that we redefine the worlds within which we operate. The first step on this path is awareness. If nurses can truly see themselves and recognize all the ramifications of their values and behaviors, the changes they make will be positive and powerful.

BIBLIOGRAPHY

Aboulafia, M. (1983). From domination to recognition. In C.C. Gould (Ed.), *Beyond domination: New perspectives on women and philosophy*. New Jersey: Rowman & Allansheld.

Albert, E. (1968). Value systems. In *The international encyclopedia of the social sciences*, Vol. 16. New York: Macmillan.

Barbour, A. & Moreno, Z.T. (1982). Role Fatigue. In *Journal of Social Issues*, Vol. 42, pp. 185-189.

Barnlund, D.C. (1982). Toward a meaning-centered philosophy of communication. In J. Stewart (Ed.), *Bridges not walls*. Reading, MA: Addison-Wesley.

Belenky, M.F., Clinchy, B.M., Goldberger, N.R., & Tarule, J.M. (1986). *Women's ways of knowing: The development of self, voice, and mind*. New York: Basic Books.

Bem, D. . (1970). *Beliefs, values, and human affairs*. Monterey: Brooks,/Cole Publishing Co.

Bernard, J. (1981). *The female world*. New York: The Free Press.

Bridges, W. (1986). Managing organizational transition. *Organizational Dynamics*, Summer, pp. 24-33.

Chodorow, N. (1978). *The reproduction of mothering*. Berkley: University of California Press.

Deutsch, M. (1973). Conflicts: Productive and destructive. In F.E. Jandt (Ed), Conflict resolution through communication. New York: Harper & Row.

Gilligan, C. (1982). *In a different voice: psychological theory and women's development*. Cambridge, MA: Harvard University Press

Gilligan ,C. & Lyons, Iahara, C.K. (1988). Collegiality as a professional virtue. In A Flores (Ed.), *Professional ideals*. Belmont, CA: Wadsworth Publishing Co.

Goffman, E. (1959). *The presentation of self in everyday life*. New York: Doubleday.

Gould, C.C. (9183). *Beyond domination: New perspectives on women and philosophy*. New Jersey: Rowman & Allansheld.

Iahara, C.K. (1988). Collegiality as a professional virtue. In A. Flores (Ed.), *Professional ideals*. Belmont, Ca: Wadsworth Publishing Co.

Leininger, M. (1985). Transcultural care, diversity, and universality: A theory of nursing. In *Nursing and Health Care*, 6, 208-212.

Lyons, N. (1983). Two perspectives on self, relationships, and morality. *Harvard Educational Review*, 53, 125-145.

Miller, J.B. (1976). *Toward a new psychology of women.* Boston: Beacon Press.

Moreno, J.L. (1962). Role theory and the emergence of self. In *Group Psychotherapy and Psychodrama*, Vol. 15, No. 2.

Tofler, A. (1990). Power shift. In Newsweek, October 15, pp. 86-92.

Will, G. (1988). The dignity of nursing. *Newsweek*, May 23, p.80.

Wilmot,W.W. (1987). *Dyadic communication.* New York: Random House.